No. 85-1277

IN THE

Supreme Court of the United States

October Term, 1985

SCHOOL BOARD OF NASSAU COUNTY, FLORIDA, et al.,

Petitioners,

vs.

GENE H. ARLINE,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF AMICI CURIAE OF DOCTORS FOR AIDS RESEARCH AND EDUCATION: NEIL SCHRAM, M.D., MERVYN SILVERMAN, M.D., GERALD FRIEDLAND, M.D., DONALD ABRAMS, M.D., DANIEL WILLIAM, M.D., HAROLD HAWLEY, M.D., ALEXANDRA LEVINE, M.D., DAVID OSTROW, M.D., Ph.D.,

(continued within)

IN SUPPORT OF RESPONDENT

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INTEREST OF AMICI CURIAE

This brief amici curiae is submitted in support of Respondent, on behalf of Doctors for AIDS Research and Education (DARE). DARE is composed of physicians and public health specialists who are experts on the disease commonly known as Acquired Immune Deficiency Syndrome (AIDS).[1]

Through this brief, Amici provide the Court with accurate and up-to-date medical facts regarding AIDS in order to correct the misinformation and distortions proffered by briefs previously filed herein by others. These facts become crucial only if the Court chooses to consider an issue not before it, the

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1 The qualifications of the individuals who constitute DARE are set forth in the Appendix to this brief.

applicability of Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794, et seq., (the "Act") to individuals infected with the AIDS virus.

Resolution of that question should await a case squarely presenting the issue, to allow development of a full record, missing here. Nevertheless, even basic available medical data demonstrate that individuals infected with the AIDS virus must be encompassed within the framework of the Act. Amici, as experts, here present these data.[2]

SUMMARY OF ARGUMENT

The scope of review in the present case is narrow. The questions this

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2 The parties to this action have consented to the filing of this brief, and their letters of consent are being filed with the Clerk of this Court.

Court certified for consideration are expressly limited to the "disease of tuberculosis." School Board of Nassau County, Florida v. Arline, 106 S. Ct. 1633, 1634 (1986). No testimony, other evidence or findings below dealt with, or even mentioned, AIDS. The Act's focus upon individualized consideration of the handicapped thus prohibits transforming this case about a woman with tuberculosis into a vehicle for speculation on the varied situations of the over one million Americans who have been afflicted with a virus causing the very different disease of AIDS.

Nevertheless, without adequate information and in the absence of a record, Petitioners would have the Court, through a broadly based decision, pre-judge issues bearing upon those infected with the AIDS virus.[3] Amici

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3 Petitioners and those supporting their petition have tried repeatedly to

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urge the Court to reject efforts to broaden the scope of the issues presented and to limit its ruling to the record before it.

The high mortality rates resulting from AIDS have created anxiety in a public uninformed about the disease,[4] an anxiety that many of Petitioners' amici attempt to feed.[5] This hysteria and the public's misguided exclusive association of the infection with certain sexual activities have brought political

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interject questions about AIDS into this case. Petitioners' Reply Brief on Writ of Certiorari discussed application of the Act to AIDS exclusively. Petitioners' Opening Brief discusses at length the Justice Department's Office of Legal Counsel's Memorandum Re: Application of Section 504 of the Rehabilitation Act to Persons with AIDS, AIDS-Related Complex or AIDS Virus (June 23, 1986) [hereinafter DoJ Memo], a copy of which Petitioners have lodged with the Court. All amici supporting Petitioners refer to the DoJ Memo in their briefs, and the brief amicus curiae of Congressman Dannemeyer, et al. speaks more about AIDS than about tuberculosis.

4 A September 1985 CBS poll found that 47% erroneously think it is possible to contract AIDS from a shared drinking glass, 32% believe in error that AIDS may be contracted from kissing, and 28% mistakenly think AIDS can be contracted from a toilet seat. Lieberson, The Reality of AIDS, N.Y. Rev. 43, 45 (Jan. 16, 1986) [hereinafter Reality]. Such misperceptions have resulted in television crews walking off the set where persons with AIDS were being interviewed, TV Crew Leaves Set of AIDS Victims Interview, N.Y. Times, Mar. 28, 1985, at B6, col. 3, and students being removed from classes because of suspicions that boyfriends of their mothers had contracted AIDS. AIDS Fear Forced Pupils Out, N.Y. Times, Oct. 4, 1985, at B1, col. 4; see also Korcok, AIDS Hysteria: A Contagious Side Effect, 133 Can. Med. A.J. 1241 (Dec. 1985).

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5 See, e.g., Brief Amicus Curiae of Cong. Dannemeyer, et al., at 18-19, n. 7. Not even the legal system has been immune from such irrational reactions. See, e.g., Richmond News Leader, Sept. 6, 1985, at 13, col. 1 (reporting dropping of charges against criminal defendant with AIDS rather than having accused enter courtroom).

tensions into the medical arena.[6] Amici seek to help resolve these tensions by providing an accurate understanding of the nature of AIDS.

Amici first describe the nature of the AIDS virus, based on articles in authoritative medical journals. The studies reported demonstrate that the AIDS virus is difficult to contract.[7] Hence, the Centers for Disease Control ("CDC")[8] recommends that individuals who have been infected with the virus be permitted to continue to work and attend school.[9]

Second, Amici demonstrate that persons infected with the AIDS virus are handicapped individuals under the Act's provisions. Those infected have physical and mental impairments that substantially limit major life activities. They also are regarded by others as having such impairments.

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6 See Medical Experts Assail Initiative on AIDS: Officials Dismiss Claims Made by Supporters of LaRouche-Backed Prop. 64, L.A. Times, Aug. 3, 1986, § 1, at 3, col. 2; Eu v. Male, No. 341940, slip op. (Sac., Cal. Sup. Ct. Aug. 8, 1986) (ordering removal of "medical data" -- erroneously asserting that casual transmission of AIDS virus has been shown to occur -- from argument in favor of quarantine initiative in state ballot pamphlet).

7 See, e.g., Sande, The Case against Casual Contagion, 314 New Eng. J. Med. 380 (Feb. 1986) [hereinafter Casual].

8 The CDC is the federal agency charged with protecting the nation's public health by providing leadership and direction in the prevention and control of disease. The United States Government Manual 1985-86 276 (1985).

9 Recommendations for Preventing Transmission of Infections with Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus In The Workplace, 34 Morbidity and Mortality Weekly Report [hereinafter "MMWR"] 681 (Nov. 1985) [hereinafter Workplace]; Education and Foster Care of Children Infected With Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus, 34 MMWR 517 (Aug. 1985) [hereinafter Education].

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The Act does not exclude conditions like AIDS. Instead, it requires that each person infected with the AIDS virus be permitted to participate in all federally funded programs, unless and until individualized symptoms of the disease render that person unqualified to perform the activity in which he or she is engaged.

ARGUMENT

I. A REVIEW OF THE MEDICAL AUTHORITIES DEMONSTRATES THAT PERSONS INFECTED WITH THE AIDS VIRUS ARE HANDICAPPED INDIVIDUALS.

Those infected with the AIDS virus are the subject of public ignorance and unfounded fears, just like other handicapped persons whom Congress sought to protect in passing the Act. Absent legal protection, they are subjected to irrational discrimination and exclusions on the basis of their impairments, at a

cost both to themselves and society. Understanding what AIDS is shows that there is no reason to treat persons exposed to the AIDS virus any differently from those with other handicaps.[10]

A. What Is AIDS?

Acquired Immune Deficiency Syndrome (AIDS) is the clinical manifestation of a dysfunction of the human immune system caused by a recently discovered virus.[11]

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10 While Amici have felt it important to present the medical facts set forth in this brief, the record in the present case is insufficient to support a decision reaching AIDS issues. Cf. Commonwealth of Massachusetts v. Painten, 390 U.S. 560, 561 (1968) (dismissing writ because record not sufficiently clear and specific to permit decision of issues).

11 Gallo, et al., Frequent Detection and Isolation of Cytopathic Retroviruses (HTLV-III) from Patients With AIDS and At Risk For AIDS, 224 Sci. 500 (May 1984). The AIDS virus has received several names: Human T-Lymphotropic Virus Type III (HTLV-III); Lymphadenopathy-

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The human immune system works through a complicated process by which certain white blood cells are able to recognize and destroy foreign agents that enter the body. The AIDS virus kills the immune system's T-helper cells -- the primary warriors of the cell-mediated immune system[12] -- leaving those infected with the virus vulnerable to diseases

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Associated Virus (LAV); AIDS-Associated Retrovirus (ARV); and, most recently, Human Immunodeficiency Virus (HIV). Compare Langone, AIDS, 6 Discovery 28, 30 (Dec. 1985) [hereinafter AIDS] and DoJ Memo, supra note 3 (both using former terminology) with Coffin, et al., Human Immunodeficiency Viruses (Letter), 232 Sci. 697 (May 1986) (proposing HIV terminology). This brief refers to the virus as simply the "AIDS virus." Those whose blood indicates they have been exposed to the virus are termed "seropositive."

12 A. Fettner & W. Check, The Truth About AIDS 44 (1984); Jaret, The Wars Within, 169 Nat'l Geographic 702, 723 (June 1986) (photographic essay on immune system and AIDS virus).

(called "opportunistic" infections) that do not affect healthy people.[13]

To date, there is no vaccine against nor cure for AIDS. Education is crucial in bringing about changes in behavior, the only known means of prevention.[14]

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13 As of July 29, 1986, the total reported number of persons with AIDS in the U.S. has exceeded 23,000, over half of whom have died. CDC, Weekly Surveillance Report - United States AIDS Program, July 29, 1986 [hereinafter CDC 7/29/86 Rep.].

14 U.S. Off. Tech. Assessment, Review of the Public Health Service's Response to AIDS: A Technical Memorandum 49 (Feb. 1985); see also Public Health Service Plan for the Prevention and Control of the AIDS Virus: Report of the Coolfant Conference, June 4-6, 1986, at 11-12 [hereinafter Coolfont Rep.], reprinted in principal part in 101 Pub. Health Rep. 341 (July-Aug. 1986); Self-Reported Behavioral Changes Among Homosexual Men -- San Francisco, 34 MMWR 613 (Oct. 1985) [hereinafter Behavioral Changes] (demonstrating that, as a result of education, the percentage of homosexual and bisexual men engaging only in non-promiscuous safe-sex practices rose from 61% in April 1984 to 81% one year later).

While fully developed AIDS is the best known condition associated with the AIDS virus, a range of symptoms may result from infection.[15] Recently, manifestations of the infection have been classified pursuant to four groups of symptoms and several sub-classes:[16]

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15 See Revision of the Case Definition of Acquired Immunodeficiency Syndrome for National Reporting -- United States, 34 MMWR 373, 374 (June 1985) [hereinafter Revision of Definition]; see also "The Case Definition of AIDS Used by CDC for National Reporting" (Aug. 1, 1985), Attachment A to DoJ Memo [hereinafter CDC Definition].

16 Previously, persons with the AIDS virus were classed as (1) having either AIDS; (2) having AIDS-Related Complex ("ARC"), which loosely referred to the conjunction of such symptoms as swollen lymph-nodes, fever, weight loss, fatigue, and night sweats, Kalish & Schlossman, The T4 Lymphocyte in AIDS, 313 New Eng. J. Med. 112 (July 1985), or (3) being asymptomatic but testing positive. See Reality, supra note 4. See also DoJ Memo, supra note 3, at 9 and n.20 (using former classification system).

(I) early acute, though transient, signs of the disease; (II) asymptomatic infection; (III) persistent swollen lymph-nodes; and (IV) presence of opportunistic disease and/or rare types of cancer, including one known as Kaposi's Sarcoma.[17]

Individuals in all four of the CDC classifications suffer from impairments to their physical systems. For example, even those who are asymptomatic have abnormalities in their hemic and reproductive systems making procreation and childbirth dangerous to themselves and others.[18]

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17 CDC, Classification System for Human T-Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus Infection, 105 Annals Internal Med. 234 (Aug. 1986) [hereinafter Classification].

18 Scott, et al., Mothers of Infants with the Acquired Immunodeficiency

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Symptoms classified under Class IV most severely impair the body's systems.[19] Such patients generally have

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Syndrome Evidence for Both Symptomatic and Asymptomatic Carriers, 253 J. A.M.A. 363 (June 1985) [hereinafter Mothers] (indicating 30-50% of children born to seropositive mothers develop AIDS and that seropositive women who become pregnant are at increased risk of developing Class IV AIDS themselves). As a result, the hemophiliac community has recommended that those who are seropositive give "serious consideration . . . to deferring pregnancy." Hemophilia Info. Exchange, AIDS, HTLV-III and Hemophilia: Your Questions Answered, AIDS Update 4 (Apr. 1986); see also Provisional Public Health Service Inter-Agency Recommendations for Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome, 34 MMWR 1 (Jan. 1985) (advising persons with any evidence of AIDS virus infection to avoid transmission through sexual intercourse and to refrain from donating sperm, blood, etc.).

19 Class IV includes four subclasses: 1) constitutional diseases; 2) neurologic diseases; 3) secondary infections diseases [including infections of pathogens such as protozoa (amoeba-like organisms) or helminthics (worms); the

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multiple symptoms. While the lymphatic and hemic systems are the bodily systems most commonly affected,[20] attack upon the respiratory system causes the greatest number of deaths. Pneumocystis carinii pneumonia (PCP) is present in 58% of all AIDS patients. This uncommon form of pneumonia and a spectrum of other respiratory infections frequently bring about shortness of breath and severe chest pains.[21]

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most common are pneumocytis carinii pneumonia, diseases caused by fungi (molds such as candidiasis or cryptococcus), viral infections (like cytomegalovirus and herpes simplex) and bacterial infections (such as mycobacterium)]; and 4) other clinical symptoms not classifiable in other categories. See Classification, supra note 17; see also Revision of Definition, supra note 15.

20 Brettman, Serologic and Epidemiologic Assessment of AIDS Risk, 3 Infections in Med. 18, 20 (Jan. 1986) [hereinafter Serologic Assessment].

21 PCP is the most prevalent opportunistic disease affecting those with AIDS.

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Neurological disorders, including dementia, AIDS-virus induced encephalitis, and motor and behavioral changes are also common.[22] In addition, various bacteria and fungi attack the cardiovascular system, often resulting in congestive heart and renal failure.[23] Visual abnormalities, and even blindness, result from viral eye infections,[24] while the intestinal track is

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Although persons with adequately functioning immune systems are fully able to defend themselves against PCP, it has been fatal to 45% of those AIDS patients stricken with it. Daul, et al., Acquired Immnune Deficiency Syndrome: An Update and Interpretation, 51 Annals Allergy 351, 352-53 (Sept. 1983).

22 Navia, et al., The AIDS Dementia Complex: I. Clinical Features and II. Neuropathology, 19 Annals Neurology 517 & 525 (Apr. 1986).

23 Cohen et al., Congestive Cardiomyopathy in Association with the Acquired Immunodeficiency Syndrome, 315 New Eng. J. Med. 628 (Sept. 1986).

24 Friedman et al., Cytomegalovirus Retinitis: A Manifestation of the

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attacked through persistent month-long bouts of diarrhea.[25] In fact, it is fair to say that there is not a single system of the body that is not debilitated by the ubiquitous infections to which the body is susceptible after infection by the AIDS virus.

Clearly, these conditions drastically affect most major life activities. The cited studies illustrate that people with AIDS may have difficulty caring for themselves, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working, among other life functions.

Acquired Immune Deficiency Syndrome (AIDS), 67 Brit. J. Opthamology 372 (June 1983).

25 Serologic Assessment, supra note 20, at 20.

The most common way of determining whether someone has been exposed to the AIDS virus is to investigate whether antibodies to the virus (indicating previous infection) are present in the person's blood.[26] Although no one yet knows exactly how many of the persons testing positive for antibodies to the AIDS virus ultimately will develop cases of AIDS,[27] estimates run to between 20% and 30%.[28]

Between 1 and 1.5 million people in the United States are estimated to be seropositive at present.[29] The impact of AIDS on the economy will be enormous if all infected with the AIDS virus can be summarily excluded from the workforce while they are able to work.[30]

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26 See Blattner, et al., Epidemiology of Human T-Lymphotropic Virus Type III and the Risk of Acquired Immunodeficiency Syndrome, 103 Annals Internal Med. 665 (Nov. 1985). At present, a person's blood is determined to have antibodies to the AIDS virus after repeated trials with one test (the ELISA test), followed by a more specific confirmatory test (Western Blot). Id. (The confirmatory test is necessary because the ELISA test has a significant potential for error. Carlson, et al., AIDS Serology Testing in Low- and High-Risk Groups, 253 J. A.M.A. 3405 (June 1985).)

27 Norman, AIDS Trends: Projections From Limited Data, 230 Sci. 1018 (Nov. 1985) [hereinafter AIDS Trends].

28 Coolfont Rep., supra note 14, at 5, 7 (factors determining expression and progression of the disease in individuals largely unknown); see Update: Acquired Immunodeficiency Syndrome-United States, 35 MMWR 17 (Jan. 1986) [hereinafter Update]. One interesting study showed that four years after 9 newborns received transfusions of plasma from a single donor who, to his ignorance, had been infected with the virus, two had died from AIDS and three had ARC symptoms, but the other four were healthy. Lange, et al., HTLV-III/LAV Infection in Nine Children Infected by a Single Plasma Donor, 154 J. Infectious Diseases 171 (July 1986) [hereinafter Nine Children].

29 Coolfant Rep., supra note 14, at 4; Update, supra note 28.

30 Among those Americans thus far diagnosed with fully-developed AIDS, 40%

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The incubation period for onset of clinical AIDS is several years after infection, with an average of 4.5 years.[31] Individuals who ultimately will develop full AIDS are clearly employable during the prolonged incubation period.[32] Indeed, many persons who are infected with the virus may nonetheless live disease-free all their lives.[33] For example, of the

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are minorities (25% are Black and 14% are Hispanic). See CDC 7/29/86 Rep., supra note 13; Bakeman, et al., AIDS Risk-Group Profiles in Whites and Members of Minority Groups, 315 New Eng. J. Med. 191 (July 1986). All but 7% of those currently infected in the U.S. are male. Women and AIDS, Newsweek 60 (July 14, 1986).

31 Periods of up to 7 years have been reported thus far. Peterman, et al., Epidemiology of the Acquired Immunodeficiency Syndrome (AIDS), 7 Epidemiological Rev. 1 (1985); AIDS Trends, supra note 27, at 1018.

32 Workplace, supra note 9.

33 Health & and Pub. Policy Comm'n, Amer. C. Physicians, & the Infectious

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approximately 20,000 hemophiliacs in the United States (90% of whom are now seropositive), only about 100, or 2%, have fully developed AIDS.[34] This is particularly significant because most hemophiliacs were infected at the earliest stages of the epidemic as a result of direct injections of infected blood.[35] Thus, the data demonstrate

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Diseases Soc'y Amer., Position Paper: Acquired Immune Deficiency Syndrome, 104 Annuals Internal Med. 575 (Apr. 1986) [hereinafter Position Paper]; see also Mothers, note 18, supra.

34 Levine, The Acquired Immunodeficiency Syndrome In Persons With Hemophilia, 103 Annals Internal Med. 723 (Nov. 1985); see also Melbye, et al., Long-Term Seropositivity For Human T-Lymphotropic Virus Type III in Homosexual Men Without the Acquired Immunodeficiency Syndrome: Development of Immunologic and Clinical Abnormalities, 104 Annals Internal Med. 496 (Apr. 1986).

35 Evatt, Coincidental Appearance of HTLV-III/LAV Antibodies in Hemophiliacs and the Onset of the AIDS Epidemic, 31 New Eng. J. Med. 483 (Feb. 1985); AIDS, supra note 11, at 50.

that almost all individuals exposed to the virus are capable of many productive years in the workplace and that, throughout their work-lives, many will remain just as productive as their co-workers who have not been infected. This fact is recognized by the government's own CDC.[36]

B. The AIDS Virus Is Not Casually Transmitted.

The AIDS virus is not spread in the air by droplet infection as are the common cold, influenza or tuberculosis.[37] Fragile and killed by most household

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36 Workplace, supra note 9; see also Recommendations for Preventing Transmission of Infection with Human T-Lymphotrophic Virus Type III/ Lymphadenopathy-Associated Virus During Invasive Procedures, 35 MMWR 221 (Apr. 1986) (CDC explanation of how surgeons with AIDS can continue to perform their duties if they take limited specified precautions).

37 See Education, supra note 9.

disinfectants including, apparently, soap and water,[38] it is spread only via specific routes by transmission of infected blood, semen or vaginal fluids (and, possibly, mother's milk) from one person to another.[39] Transmission by either semen or blood accounts for virtually all reported cases.[40]

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38 Grouse, HTLV-III Transmission, 254 J. A.M.A. 2130 (Oct. 1985) [hereinafter Transmission]; see also Recommendations for Providing Dialysis Treatment to Patients Infected With Human T-Lymphotrophic Virus Type III/Lymphadenopathy-Associated Virus, 35 MMWR 376 (June 1986) (no extraordinary precautions necessary to sanitize dialysis machine after use by AIDS patients).

39 There is no evidence of insect-borne transmission of the virus, such as by mosquitoes. Drotman, Insect-Borne Transmission of AIDS?, 254 J. A.M.A. 1085 (Aug. 1985).

40 The only reported exception to transmission by blood, semen or vaginal fluids is a single instance of a mother who possibly transmitted AIDS to her infant through breast milk.

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The routes for transmission of the AIDS virus are limited in number.[41]

Recommendations for Assisting in the Prevention of Perinatal Transmission of Human T Lymphotropic Virus Type III/ Lymphadenopathy-Associated Virus and Acquired Immunodeficiency Syndrome, 34 MMWR 721, 722 (Dec. 1985) [hereinafter Perinatal]; see DoJ Memo, supra note 3 at 11, n.28. Of course, newborns have immature immune systems. See Davis, Histopathological Changes in the Thymus Gland, 12 Annals N.Y. Acad. Sciences 493, 495 (1986).

41 In order to protect the blood supply, in 1983 the CDC looked at clusters of AIDS cases and determined certain categories of people as being at higher risks for the disease (these "high-risk" groups were then listed as hemophiliacs, homosexual/bisexual men with multiple sex partners, intravenous (IV) drug users and Haitians). Prevention of Acquired Immune Deficiency Syndrome (AIDS): Report of Inter-Agency Recommendations, 32 MMWR 101 (Mar. 1983) [hereinafter AIDS Prevention.]. Unfortunately, identification of risk groups as opposed to risk behaviors has led some to misperceive the disease as being caused by being, or being in the proximity of, a homosexual or a drug user, rather than being a disease to which certain acts (some of which are sexual) render one susceptible. For example,

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Anal intercourse has been the predominant route among cases documented to date.[42] However, transmission via

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despite public perceptions to the contrary, lesbians are the group least likely to become infected. Gay Women and Risk of AIDS, L.A. Times, Apr. 2, 1986, at V1, col. 2.

Some still cling to the "high-risk group" terminology and simultaneously claim that many cases do not fall into any known risk group, a claim which seems calculated to create concern about possible "unknown" routes of transmission. See, e.g., DoJ Memo, supra note 3, at 4, n.3; see also note 55, infra.

42 Transmission by anal intercourse is not limited to the male homosexuals and bisexuals, but also poses a risk of transmission in the heterosexual community. Melbye, et al., Anal Intercourse As A Possible Factor in Heterosexual Transmission of HTLV-III to Spouses of Hemophiliacs, 312 New Eng. J. Med. 857 (Jan. 1985); Redfield, et al., Frequent Bidirectional Heterosexual Transmission of HTLV-III/LAV Between Spouses, Proceedings of the Second Int'l Conf. on AIDS (Paris) [hereinafter Paris Conf. Proc.] 125 (June 1986) [hereinafter Bidirectional].

Anal intercourse poses more of a risk for transmission than vaginal

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vaginal intercourse also is known to occur.[43] A single penile-vaginal

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intercourse because the walls of the rectum contain numerous blood vessels and are more easily torn. See AIDS, supra note 11.

43 Kreiss, et al., Antibody to Human T-Lymphotropic Virus Type III in Wives of Hemophiliacs, 102 Annals Internal Med. 623 (May 1985); Redfield, et al., Frequent Transmission of HTLV-III Among Spouses of Patients With AIDS-Related Complex and AIDS, 253 J. A.M.A. 1571 (Mar. 1985). Widespread misinformation about the manner of transmission has led many erroneously to believe that only those in high-risk groups will be exposed to AIDS virus. Nonetheless, a greater proportional increase in heterosexual transmission is expected. By 1991, it is estimated that 7,000 fully developed AIDS cases (9% of the total in the U.S.) will be the result of heterosexual transmission. Coolfont Rep., supra note 14, at 7, 13. In some African countries, vaginal intercourse already is believed to be the primary method of transmission. Mann, et al., Prevalence of HTLV-III/LAV in Household Contacts of Patients With Confirmed AIDS and Controls in Kinshasa, Zaire, 256 J. A.M.A. 721 (Aug. 1986). Further, while in 1983, 71% of the AIDS cases in Haiti were among individuals in groups regularly engaging in high-risk activi-

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contact may be sufficient.[44]

There is a public misconception that any personal bodily contact may spread the disease. However, kissing has never been documented as a transmission route.[45] This is also true for

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ties, by 1985, 71% of the cases were among individuals outside such groups. Women and AIDS, supra note 30; see also Culmeck, et al. Seroepidemiological Studies of HTLV-III Antibody Prevalence Among Selected Groups of Heterosexual Africans, 254 J. A.M.A. 2599 (Nov. 1985) (16% of heterosexuals in Zaire and Rwanda infected). But see Female-to-Male Transmission of HTLV-III (Letters) 255 J. A.M.A. 1702 (Apr. 1986). Thus, it is important that decisions with an impact upon persons exposed to the AIDS virus be made for the population as a whole and not be based upon unscientific moral judgments of certain high-risk group behavior.

44 Peterman, Study Documents Heterosexual Transmission, 1 AIDS Alert 5 (May 1986); Some experts believe the disease can be readily transferred heterosexually. Women and AIDS, supra note 30; Bidirectional, supra note 42.

45 Casual, supra note 7; see also Infrequency of Isolation of HTLV-III

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oral-genital sex.[46]

The most direct route of transmission is through exchange of blood products. This can occur when intravenous (IV) drug users share infected needles. In addition, until AIDS was recognized, and the nation's blood supply tested, transmission occurred through the transfusion of contaminated blood. Finally, newborn infants born of infected mothers may receive contaminated blood in utero.[47]

Virus From Saliva In AIDS, 313 New Eng. J. Med. 1606 (Dec. 1985); HTLV-III Exposure During Cardiopulmonary Resuscitation, 313 New Eng. J. Med. 1606 (Dec. 1985) (paramedics giving mouth-to-mouth resuscitation to infected individuals tested negative for antibodies to the virus).

46 See Casual, supra note 6; Lymon, et al., Minimal Risk of Transmission of AIDS-Associated Retrovirus Infection by Oral-Genital Contact, 255 J. A.M.A. 1703 (Apr. 1986).

47 See Mothers, supra note 18.

Transmission to hemophiliacs has been contained through new blood treatments.[48] Because condoms appear to be effective in preventing transmission of the virus via semen,[49] and because anal intercourse can be replaced with safer sexual practices,[50] transmission among male homosexuals and bisexuals has slowed as those groups have responded to

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48 Case for Concluding Heat Treated Licensed Anti-Hemophiliac Factor Is Free From HTLV-III, Lancet 890 (Oct. 19, 1985).

49 Condoms Prevent Transmission of AIDS-Associated Retrovirus, 255 J. A.M.A. 1706 (Apr. 1986). Indeed, an agency funded in part by a grant from the U.S. Department of Health and Human Services recommends condoms as the only necessary precaution for sexual practices by hemophiliacs. Hemophilia Info. Exchange, Hemophilia and Acquired Immune Deficiency Syndrome (AIDS): Intimacy and Sexual Behavior, AIDS Update 1 (Sept. 1985).

50 CDC, 1985 STD Treatment Guidelines, 34 MMWR (Supp.) 75S (Oct. 1985) (identifying safe sexual behaviors).

education.[51] Transfusion-associated transmission also has been contained through development of antibody tests.[52]

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51 Behavioral Changes, supra note 14. But see Moss et al., Progression to AIDS in Men Seropositive for LAV/HTLV-III: One-year Followups of San Francisco General Hospital Study, Paris Conf. Proc. 152 (June 1986) [hereinafter Progression]; Coolfont Rep., supra note 14, at 7, 12 (IV drug abusers are the major reservoir for transmission to the community at large). Because of the illicit nature of IV drug users' activities, they are the most difficult group to reach with education efforts. Id.; see also Bowers v. Hardwick, 106 S. Ct. 2841 (1986) (finding no constitutional barrier to state anti-sodomy laws, which laws may make identification of those engaging in anal intercourse difficult, thereby impeding education of at-risk individuals); Paterat, et al. Serological Markers as Indicators of Sexual Orientation in AIDS Virus - Infected Men, 256 J. A.M.A. 712 (Aug. 1986) (two seropositive U.S. airmen, without known risk factor, who were tested for markers of several diseases associated with male homosexual behavior had results which placed the probability at 1 in 19,000 that they did not belong to homosexual high-risk group).

52 Provisional Public Health Service Inter-Agency Recommendations for

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These data demonstrate that transmission of the virus occurs almost exclusively via specific routes in which infected blood products, semen or vaginal fluids come into contact with another's blood. No evidence exists of "casual" transmission. Indeed, only two cases have been documented of transmission of the virus other than by the activities described above, both involving individuals acting as health care workers who failed to follow CDC guidelines while caring for AIDS patients.[53]

Screening Donated Blood and Plasma for Antibody to the Virus Causing Acquired Immunodeficiency Syndrome, 34 MMWR 1 (Jan. 1985).

53 One case concerned a mother responsible for her infected child's medical care. Although this woman behaved like a health care worker (drawing her child's blood through in-dwelling body

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The DoJ Memo's only support for its claim that the AIDS virus might be transmitted by casual contact consists of these two cases, a single instance of possible transmission through a mother's milk,[54] a subsequently retracted comment

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tubes and changing surgical dressings, among other things), she did not follow recommended CDC precautions for such individuals: she did not wear gloves or wash her hands immediately after blood or secretion contact. The CDC cautions against over-generalizing the risk factor from this case: "The contact between the reported mother and child is not typical of the usual contact that could be expected in a family setting." Apparent Transmission of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus From a Child to a Mother Providing Health Care, 35 MMWR 76 (Feb. 1986) [hereinafter Child To Mother]; see also DoJ Memo, supra note 3, at 11, n.30.

The other case concerned a health care worker who also did not follow recommended CDC precautions. She had prolonged contact with an AIDS patient's body excretions and secretions, and had chronic eczema on her hands so that her own blood was exposed to the patient's virus-containing fluids. Child to Mother, supra note 53.

54 Perinatal, supra note 40.

erroneously attributed to Dr. William Haseltine of the Harvard Medical School,[55] and the implication that cases of casual transmission lurk among what the Department of Justice inaccurately refers to as the "6%" of cases not classified in a high-risk group.[56]

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55 See DoJ Memo, supra note 3, at 13, n.38, (citing to Dershowitz, Crucial Steps in Combating the AIDS Epidemic; Emphasize Scientific Information, N.Y. Times, Mar. 18, 1986, at A27, col. 2). The substance of the comment attributed to Dr. Haseltine in the New York Times (that AIDS more than likely will be casually transmitted) was subsequently retracted and "clarified" in that same periodical. Dershowitz, On Transmission (Letter), N.Y. Times, Apr. 5, 1986, at 14, col. 8. As a result, the author of the DoJ Memo, Charles Cooper, publicly apologized to Dr. Haseltine, and added assurances from the Public Health Service that "non-sexual person-to-person contacts" in the workplace did not create a risk of transmission. U.S. Apologizes to AIDS Researcher, N.Y. Times, July 23, 1986, at D20, col. 4.

56 As of July 29, 1986, only 3.1% of cases to date are of unknown origin.

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Comprehensive research on those extensively exposed to persons with AIDS demonstrates that the AIDS virus is not spread by casual contact.[57] As a

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CDC 7/29/86 Rep., supra note 12). Moreover, although, 1,206 patients could not be placed in an identified at-risk group as of May 1985, further investigation has explained the lack of placement in nearly all cases. Update, supra note 28.

57 During the past five years over 1,750 health care workers who have treated AIDS patients have been studied. Of 666 who either had penetrated their skin with a contaminated needle or had splashed body fluids on mucous membranes (such as lips), only 26 tested seropositive and only three of these did not have an alternative possible means of transmission. Update: Prospective Evaluation of Health-Care Workers Exposed Via The Parenteral or Mucous-Membrane Route To Blood Or Body Fluids From Patients With Acquired Immunodeficiency Syndrome - United States, 34 MMWR 101 (Feb. 1985); Update: Evaluation of Human T-Lymphotropic Virus Type III/Lymphadenopathy-Associated Virus Infection in Health Care Personnel - United States, 34 MMWR 575 (Sept. 1985). In another investigation of 150 health workers with needle-stick

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result, the CDC has recommended that routine serologic testing for evidence of the AIDS virus is unnecessary for medical care workers, including those performing surgical, dental, or childbirth procedures.[58]

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injuries, not one was seropositive after four years, although some had severe penetrations. Henderson, et al., Risk of Nasocomial Infection With Human T-Cell Lymphotrophic Virus Type III/Lymphadempothy-Associated Virus in Large Cohort of Intensively Exposed Health Care Workers, 104 Annals Internal Med. 644, 647 (May 1986); see also Tsoukas, et al., "Risk of Transmission of HTLV-III/LAV From Human Bites," Paris Conf. Proc. 125 (six months after 30 health care workers were bitten or scratched by a brain-damaged hemophiliac with AIDS, none tested seropositive).

58 Recommendations for Preventing Transmission During Invasive Procedures, 35 MMWR 221 (Apr. 1986); see also Sacks, AIDS and a Surgeon, 313 New Eng. J. Med. 1017 (Oct. 1985) (two years after the death from AIDS of a surgeon who performed invasive procedures, no instance of seropositivity has been reported in any of 400 of his patients).

In no instance has a family or household member of over 17,000 AIDS patients, who was not the patient's sexual partner, contracted AIDS.[59] Seven studies of over 350 family members have failed to find any virologic evidence of transmission.[60]

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59 Child To Mother, supra note 53. But see note 53, supra.

60 Id. In one study, the contacts between family members included shared toothbrushes (7%), towels (37%), eating utensils (25%), dishes (46%), drinking glasses (48%), bed (37%), toilets (90%), and baths and showers (92%). Moreover, over 19% of the family members had kissed the patient on the lips and 83% had kissed on the cheek. Freidland, et al., Lack of Transmission of HTLV-III/LAV Infection to Household Contacts of Patients With AIDS or AIDS-Related Complex with Oral Candidiasis, 314 New Eng. J. Med. 344, 346 (Feb. 1986); see also Melbye, et al., Anal Intercourse As A Possible Factor In Heterosexual Transmission of HTLV-III to Spouses of Hemophiliacs, 312 New Eng. J. Med. 857 (Mar. 1985) (no members of any hemophiliac household, except sexual partners, have been found

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In light of the case against casual transmission, CDC has recommended that children infected with AIDS be permitted to attend school within limited precautionary guidelines.[61] Similarly, CDC has determined that persons with AIDS should be permitted unrestricted access to work in food service, health care, and other work settings.[62] Summarizing

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to be exposed to the virus). Compare above scientific studies with Brief of Cong. Dannemeyer, et al., at 19 n.7 (admitting that there are no known cases of transmission by saliva or air, but baldly asserting [based upon a miscitation to a publication that admits to being "biased in favor of believing the worst" about AIDS, McKeever, The Number One Issue, AIDS Update Newsletter 1 (Apr. 1985)] that there supposedly is a "consensus" among "some [unnamed] doctors" that AIDS may be passed by kissing, mouth-to-mouth resuscitation and sharing of glasses or toothbrushes).

61 Education, supra note 9.

62 Indeed, the CDC unqualifiedly has concluded that "[t]he kind of nonsexual

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all the data arguing against casual transmission, an editorial in the New England Journal of Medicine urged: "It is now time . . . to take a more influential and active role in quelling this hysteria over the casual transmission of AIDS."[63]

C. Protecting Persons Infected With The AIDS Virus Against Discrimination And Exclusion Would Not Adversely Affect The Public Health Powers Of Government.

Because transmission of the AIDS virus cannot occur casually,[64] the

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person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of HTLV-III/LAV." Workers infected by the AIDS virus "should not be restricted from using telephones, office equipment, toilets, showers, eating facilities, and water fountains." Workplace, supra note 9, at 682, 694.

63 Casual, supra note 7.

64 See District 27 School Bd. v. Bd. of Educ., 130 Misc. 2d 398, 502 N.Y.S.2d

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prestigious American College of Physicians has adopted the position that

> [Q]uarantining persons with AIDS or persons who have been exposed to [the AIDS virus] . . . is an unjustified invasion of individual liberty and privacy. . . . [Q]uarantine . . . would not be productive. In fact, it would communicate a false sense of security . . . [so that some] might believe that the incarceration of such persons makes it safe to engage in sexual and drug practices known to transmit the . . . infection.[65]

Thus, the spectre painted by Petitioners

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325 (1986) (holding that children with AIDS were not required by law to be excluded from school system because the risk of transmission in the school setting is nonexistent).

65 Position Paper, supra note 33, at 578 (emphasis in original) (adding that quarantine likely would result in non-reporting of many cases and loss of cooperation of those whose activities place them at risk for the disease); see also Coolfont Rep., supra note 14, at 14; Local Health Officers Meet in Washington to Make Recommendations to Mayors, 3 AIDS Info. Exchange 1, 5 (Feb. 1986).

and others[66] of public health laws being rendered impotent as a result of coverage of AIDS under laws protecting the handicapped is without substance.

The medical profession has recommended that persons infected with the AIDS virus fully participate in life's activities, with all individuals (infected or not) remaining responsible for preventing exposure. Given the virus' limited routes of transmission, this is easily done, if people are adequately educated. Thus, quarantine is neither necessary nor constructive.[67]

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66 Brief of Petitioners, at 26-27, n. 5; Brief of the United States, at 16, n.14; Brief of Cong. Dannemeyer, et al., at 14-16.

67 The problem Petitioners and their amici pose is, in any event, nonexistent. If in extreme cirumstances, quarantine were justified for a particular individual because of real dangers to others in the workplace, that person would no longer be "otherwise qualified" under the Act. See infra, pp. 59-62.

II. THE LEGAL AUTHORITIES ESTABLISH THAT PERSONS INFECTED WITH THE AIDS VIRUS ARE PROTECTED UNDER THE ACT.

A. Persons Infected With The AIDS Virus Are Handicapped Within The Meaning Of The Statute.

A handicapped person, entitled to protection under Section 504 of the Act, is any person who has (1) a physical or mental impairment which (2) substantially limits one or more of a person's major life activities, as well as any person with a record of, or who is regarded as having, such an impairment.[68] The terms "physical impairment"

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68 Rehabilitation Act of 1973, 29 U.S.C.A. § 706(7)(B) (1985). Hence, not only can a person's impairment make the person handicapped, the way the person subjectively is viewed by others can do so also. Congress thus equated the rights of those mistakenly treated as handicapped with those with a verifiable medical impairment. This definition has no counterpart in other federal law. See, e.g., Social Security Act, 42

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and "major life activities" are elaborated upon by regulations.[69]

Under the regulations, a physical impairment includes:

> any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine. . . .

U.S.C.A. § 423(d) (1983) (generally requiring "medically determinable" impairment for determination of disability). See also U.S. Civ. Rts. Comm'n, Accommodating the Spectrum of Abilities 6-10 (1983) (calling the statute's approach a "major conceptual advance[]" and the "most comprehensive and useful definition to date").

69 These regulations have been approved by Congress. See Consolidated Rail Corp. v. Darrone, 104 S. Ct. 1248, 1255 n.15 (1984). They also have been copied virtually verbatim by most federal agencies, including the Dept. of Justice, 28 C.F.R. § 41 and the Dept. of Education, 34 C.F.R. § 104.

45 C.F.R. § 84.3(j)(2)(i)(A) (1985). All persons with fully developed AIDS unquestionably have such physical impairments.[70]

So too do those who appear asymptomatic. In the terms of the regulations, those infected with the virus, even if asymptomatic, have a "physiological disorder or condition . . . affecting one or more" of the listed body systems: specifically the reproductive, hemic and lymphatic systems.[71] Moreover, those infected by the virus in many instances are regarded by others (although erroneously so) as

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70 See supra, pp. 12-17. Indeed, even the Justice Department has "little difficulty concluding that the disabling effects of AIDS on its victims constitute 'impairments.'" DoJ Memo, supra note 3, at 22.

71 See supra, note 18.

having the physical impairments of those with fully developed AIDS.[72]

Further, the physical impairments those with AIDS as well as those infected with the AIDS virus have (or are regarded as having) "substantially limit[ ] one or more of such person[s'] major life activities." 29 U.S.C.A. § 706(7)(B). The regulations specify that the term "major life activities" includes, but is not limited to "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working." 45 C.F.R. § 84.3(j)(2)(ii). In fully developed cases of AIDS, many (if not all) of these functions are substantially limited.[73]

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72 See discussion infra, at pp. 48-50.

73 See supra, pp. 12-17, describing among others, physical impairments which

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But those who remain asymptomatic throughout their normal lives also have an impairment of the blood and reproduction systems that "substantially limits one or more of such person's major life activities." Both procreation and sexual intercourse are substantially limited for such individuals because the virus is readily transmitted to sexual partners (especially by activity leading to conception) and to children so conceived.

Reproductive and related activities must be classified as "major life

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limit caring for oneself, performing manual tasks, learning and working (dementia), walking (neurological motor changes), seeing (cytomegalovirus retinitis) and breathing (PCP). Again, even the Justice Department admits that this test is met as to those with fully developed AIDS. DoJ Memo, supra note 3, at 22-23 and n.63 (noting that "AIDS limits the major life activity of resisting diseases").

activities." This Court repeatedly has recognized the centrality of procreation to the life of citizens: "The rights to conceive and to raise one's children have been deemed 'essential,' 'basic civil rights of man,' and '[r]ights far more precious . . . than property rights'. . . ." Stanley v. Illinois, 405 U.S. 645, 651 (1972) (citations omitted).

Those infected with the AIDS virus must limit sexual activity, especially activity in which infected semen or vaginal secretions come into contact with a partner's bodily fluids,[74] which

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74 In many jurisdictions, willful exposure of another to disease is a crime. See, e.g., Cal. Health & Safety Code § 3353 (West 1979). Even when legality is not at issue, concern for a partner limits the sexual expression of those infected with the AIDS virus. A recent study of those voluntarily

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of course is exactly the activity needed for procreation. Limitations on procreative and sexual behavior do not arise solely out of concern for transmitting the virus to partners. The high risk of passing the infection to any child born to an AIDS-infected couple makes procreation undesirable and dangerous. Moreover, there is danger to the infected mother herself, since pregnancy places demands on an expectant woman's immune system that substantially increase the degree to which opportunistic infections

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testing for AIDS antibodies found that the most common reasons individuals test is out of concern for infecting others (71%). Even though there already have been considerable changes away from high-risk activities, more than half those questioned indicated that the test would further affect risk reduction behaviors. Dlugosch, et al., AIDS Antibody Testing: Evaluation and Counseling, 1 Focus: Rev. of AIDS Res. 1 (July 1986).

associated with AIDS can occur in her own body. Finally, there is some evidence that engaging in sexual activity increases the susceptibility of seropositive men to fully develop AIDS.[75]

In addition to having life-affecting impairments to their hemic, lymphatic, and reproductive systems, persons who are seropositive also are regarded as suffering the same impairments as those who have fully developed

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75 See supra, note 18; Perinatal, supra note 40; AIDS Prevention, supra note 41; and Progression, supra note 51. One commentator summarized the situation as follows: "For the individual, knowledge of virus infection spells almost inevitable personal anguish. Women are advised not to become pregnant, since they may infect the fetus. For men or women, pursuing marriage or even intimate relationships is fraught with extraordinary emotional trials." Eckholm, Screening of Blood for AIDS Raises Civil Liberties Issues, N.Y. Times, Sept. 30, 1985, A1, col. 2.

AIDS.[76] For example, the insurance industry has advocated mandatory testing to screen out seropositive persons on the assumption that these persons are likely to develop AIDS and incur associated health care costs.[77] Employers fear increased costs of employee benefits as well as negative publicity associated with AIDS and those who are seropositive.[78]

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76 The Justice Department further has admitted that someone who is only seropositive "may . . . be handicapped under Section 504 if he is perceived as suffering from the disability effects of AIDS or ARC." DoJ Memo, supra note 3, at 28 and 29 n.74.

77 See, e.g., Keppel, Insurers Try to Screen Out AIDS Cases, L.A. Times, § 4, at 1, col. 1 (Oct. 11, 1985).

78 See CCH, AIDS: Employer Rights and Responsibilities 29 (1985); see also Shipp, Physical Suffering is Not the Only Pain AIDS Can Inflict, N.Y. Times at A8, col. 1 (Feb. 7, 1986) (describing employer and public reaction to persons

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These examples illustrate the predicament faced by seropositive persons, most of whom may never develop any obvious debilitating symptoms. Solely because of the presence of the AIDS virus, these individuals are regarded as having AIDS and its associated problems. As a result, they face the same discrimination as do persons with fully developed AIDS.

To date, the only final reported AIDS employment discrimination case found the condition to be a handicap.[79]

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perceived as having AIDS). Because of a similar fear arising from the high costs of caring for AIDS patients, and despite opposition from public health officials in his department, Secretary of Health and Human Services Otis Bowen signed an order in February 1986 that would require testing of all permanent immigrants to the United States. Cimons, All Immigrants Face AIDS Test, L.A. Times, §1, at 1, col. 3 (Feb. 4, 1986).

79 Shuttlesworth v. Broward County Office of Management & Budget Policy,

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Federal administrative regulations and rulings are in accord.[80] Most

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FCHR 85-0624, slip op. (Fla. Comm'n on Human Relations, Dec. 11, 1985), reprinted in Daily Lab. Rep. (BNA) No. 242, E-1, E-5 (Dec. 17, 1985) (decided under statute modeled after § 504).

80 Persons with AIDS are presumed to be disabled under supplementary security income regulations. 20 C.F.R. § 416.934(k) (1986). Further, the Dept. of Health and Human Services Office of Civil Rights' ("OCR's") regional offices have concluded that AIDS and less-developed forms of the infection are covered under the Act. OCR Region IV Letter Ruling re Complaint No. 04-84-3096 (Aug. 5, 1986) (decided after release of DoJ Memo); OCR Region IX, Your Rights as a Person with AIDS or ARC (undated release); see also Education, supra note 9 (CDC considered the protection of handicapped AIDS-infected children under Section 504 in developing recommendations). Even an internal memo prepared by the civil rights division of the Justice Department prior to preparation of the DoJ Memo concluded that those suffering from AIDS or related conditions are entitled to protection under the Act. Note, AIDS and Employment Discrimination under the Federal Rehabilitation Act of 1973 and Virginia's Rights of Persons with Disabilities Act, 20 U. Richmond L. Rev. 425, 432 (1986).

commentators also agree that discrimination against someone infected with the AIDS virus squarely falls within the scope of conduct prohibited by the Act.[81] Thus, individuals, infected with the AIDS virus are "handicapped individuals" within the meaning of Section 504 of the Rehabilitation Act.

Section 504 does not expressly exclude those infected with the AIDS virus (or any other disease which has a

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81 See, e.g., Note, supra note 80, at 439 ("Forcing employers to accept facts . . . and discontinue discriminatory practices has been the role of the courts in other areas of civil rights litigation and it is equally appropriate here"); Smith, et al., High Court Eyed for Guidance on AIDS as Handicap, Legal Times 35, 39 (June 30, 1986) ("In view of the 1 million or more Americans estimated to be infected with this AIDS virus, the Supreme Court may be understandably reluctant, without further legislative directive, to exclude contagious diseases from protection of the federal handicap law").

contagious aspect) from coverage. Petitioners and their amici hence make an unfounded attempt to establish an implied exclusion of contagious diseases from the Act's scope.[82]

Yet, in 1978, when Congress amended the statutory definition to expressly

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82 See Brief of Petitioners, at 25-28; see also Brief of Solicitor General at 16-18; Brief of Cong. Dannemeyer, et al., at 8-14. Indeed, their argument is not so much exclusion at all, but instead that individuals with diseases such as AIDS (or TB) supposedly are inevitably discriminated against "solely on the basis of" contagion (or expected future deterioration) and not on the basis of their handicapping conditions at all -- as if contagion (or deterioration) could somehow be divorced from other aspects of the handicapping condition. Rather, the contagion is an integral part of the handicapping condition. Discrimination on the basis of contagion, thus is discrimination on the basis of the handicap. To allow the facile distinction between the two would render the protection given by the Act to those with contagious (or deteriorating) diseases illusory. See infra, note 86.

exclude alcoholics and drug addicts whose current use of alcohol or drugs precludes adequate or safe job performance,[83] it chose not to exclude contagious disease from coverage.[84]

Adoption of a blanket implied exception for contagious diseases would undermine Congressional intent to evaluate each claimed handicap on an

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83 Rehabilitation Act of 1973, § 504, 29 U.S.C.A. § 706(7)(B) (1985). Significantly, even there, Congress did not entirely remove the handicapping conditions of alcoholism and drug addiction from coverage, but instead required case-by-case determinations as to whether each individual's current condition prevents adequate or safe job performance.

84 As this Court noted in Grove City College v. Bell, 104 S. Ct. 1211, 1217 (1984), because antidiscrimination laws arise from concerns of broad scope, this Court has been "reluctant to read [into the statute] a limitation not apparent on its face." Interestingly, the Solicitor General himself argued, in Bowen v. American Hospital Assoc., 106 S. Ct. 2101 (1986), Section 504.

individual basis, which the Act expressly contemplates. Courts routinely have effectuated this intent.[85]

Moreover, many disabilities that Congress defined as severe under related provisions are virally induced and therefore contagious in some way at some point in time.[86] Given the high

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85 See, e.g., Doe v. New York Univ., 666 F.2d 761, 775 (2d Cir. 1981) (evaluating claim of mental impairment by reference to plaintiff's medical records and treatment by defendant).

86 Rehabilitation Act of 1973, 29 U.S.C.A. § 706(13) (1985) defines a "severe handicap" requiring multiple services over an extended time period as a disability which results from, among other conditions, "blindness, cancer, multiple sclerosis, muscular dystrophy, neurological disorders (including stroke and epilepsy) paraplegia, guadriplegia, and other spinal conditions. . . ." Of these, many have a manifestation presumed contagious at some stage. For example, blindness is a symptom of cytomegalovirus retinitis; viruses are suspected of causing many forms of cancer, and the Epstein-Barr virus has been

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incidence of contagiousness in disabilities Congress explicitly intended to cover, this Court should not circumscribe the congressionally mandated definition of handicap under Section 504 by finding an implied exception for contagious diseases.[87]

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linked to lymphoma; multiple sclerosis, encephelitis, and polio are virally induced; and polio and Guillian-Barre Syndrome can result in paraplegia. Mandell, et al., Principles and Practices of Infectious Diseases (2d ed. 1984).

Courts also have regularly recognized persons with such diseases as falling within the protection of § 504. See e.g., Pushkin v. Regents of Univ. of Col., 658 F.2d 1372 (10th Cir. 1981) (persons with multiple sclerosis covered). See also Floum, The Federal Rights of Hansen's Disease (Leprosy) Patients at Kalaupapa, 6. U. Haw. L. Rev. 507 (1984) (noting HHS findings of coverage of those with leprosy under § 504). Many of these diseases, like AIDS, are contagious only in limited ways and may never affect the workplace. The differences among them further cautions against a broad ruling regarding "contagious" diseases.

87 The same holds true for any type of blanket implied exception for

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To prevent stereotypes and ill-founded fears from vitiating Section 504, contagiousness or risk to

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deteriorating or progressive diseases. Congress specifically protected the progressive and frequently deteriorating diseases of cancer, multiple sclerosis, muscular dystrophy, and cystic fibrosis, without regard to the potential progress of the condition. See Rehabilitation Act of 1973, 29 U.S.C.A. § 706(13) (1985). Further, at the time HEW promulgated its regulations HEW stated that it "continue[d] to believe. . . that it has no flexibility within the statutory definition to limit the term to persons who have those severe, permanent, or progressive conditions that are most commonly regarded as handicaps." 45 C.F.R. Pt. 84, App. A at 310. Accordingly, courts have refused to speculate about the future development of a disease, see, e.g., Bentivegna v. Dept. of Labor, 694 F.2d 619, 623 (9th Cir. 1982) ("allowing remote concerns [about future health of diabetic] to legitimize discrimination would vitiate the effectiveness of section 504"). Rather, courts have held persons with progressive diseases also to be protected by Section 504. See, e.g., Mantolete v. Bolger, 767 F.2d 1416 (9th Cir. 1985) (person with epilepsy covered; remanded to determine if otherwise qualified); Plummer v. Branstad, 731 F.2d 574 (8th Cir. 1984) (Huntington's Chorea).

self and others should be permitted to justify differential treatment of a handicapped individual only when the risk of transmission of illness is significant, which is not the case with AIDS. In New York State Ass'n for Retarded Children v. Carey, 612 F.2d 644 (2d Cir. 1979), the court struck down under section 504 a decision of the State Board of Education to exclude certain mentally retarded children from school classes because they were carriers of the virus, hepatitus B. The court held that the Board failed to demonstrate that the health hazard posed by these children was "anything more than a remote possibility . . ." and that "the activities that occur in classroom settings were not shown to pose any signficant risk that the disease would be transmitted from one child to

another." Id. at 650. [88]

B. Persons Infected With The AIDS Virus Are Not, Solely By Virtue Of Their Infection, Automatically Rendered Not Otherwise Qualified For Any Job.

Employer fears cannot provide the underpinnings of an implied exception to coverage under the Act.[89] Concerns about contagiousness or risk to self and others are relevant only to whether a handicapped individual is "otherwise qualified" for the job.[90] Again,

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88 Cf. Doe v. New York Univ., 666 F.2d at 777 (requiring evidence of a significant risk of harm to self or others to justify exclusion of individual with history of mental illness); Mantolete, 767 F.2d at 1422 (rejecting a "mere elevated risk" standard).

89 Such fears readily can be likened to the "outmoded stereotypes" that employers historically have relied on to exclude and penalize women, and that this Court consistently has refused to sanction. See, e.g., Califano v. Goldfarb, 430 U.S. 199, 207 (1977).

90 The Eleventh Circuit remanded the present action for evaluation of the

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however, this determination requires a case-by-case evaluation of the individual's handicapping condition in relation to the specific requirements of the job in question. [91]

As shown above, persons infected with the AIDS virus are not contagious in the workplace and do not pose any risk of transmission to their co-workers. Contagiousness in other

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risk posed by Respondent's health condition. Arline v. School Bd. of Nassau County, 772 F.2d 759, 765 (11th Cir. 1985). Consequently, resolution of this question based on the present record is premature and the writ of certiorari as to this question should be dismissed as improvidently granted. See, e.g., Taggarty v. Weinaker's, Inc., 397 U.S. 223 (1970).

91 See Mantolete, 767 F.2d at 1423; see also Southeastern Community College v. Davis, 442 U.S. 397 (1979) (deciding whether hearing impairment rendered applicant for nursing program not otherwise qualified for reasons of patient safety).

settings is simply not relevant to whether they are "otherwise qualified" for a specific job.

Persons infected with the virus can work for years, both safely and well. Currently available evidence indicates most of these infected persons will remain asymptomatic. Only when and if they are no longer able to work or their performance is unsatisfactory may individuals infected with the AIDS virus be considered not "otherwise qualified." This must be so because, under section 504, only present job performance may be considered in determining whether a handicapped individual is "otherwise qualified" for a job.[92]

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92 Who should bear the social costs of AIDS is a policy decision requiring extensive study far beyond the scope of this case. Clearly, a decision on this

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CONCLUSION

Emotional reactions steeped in ignorance and prejudice are precisely the ill the Act was designed to counter. This Court should not sanction public hysteria as a justification for discrimination. Exclusion of persons infected with the AIDS virus from the workforce would wreak drastic consequences on millions of Americans and their families. Not only would victims be subjected to

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issue is premature and unwarranted in the present case.

As noted above, however, seropositive individuals cannot be barred from employment because of employers' speculative fears or concerns about future costs. Cf. Bentivegna, 694 F.2d at 623. Congress must have intended a policy which allows those who now are able to work to do so. Otherwise, discrimination based on concerns about later condition or the coverage of progressive disabilities caused by other diseases would have been specifically excluded instead of included. See supra, note 87.

extreme personal hardship,[93] but the nation's economic health would be strained by the millions of individuals forced to rely solely on public benefits for their living and medical expenses, whether or not they are actually incapable of productive employment.[94]

For the reasons set forth above, this Court must not extend the scope of this case nor issue a broad ruling which

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93 In addition to loss of needed financial support, being fired due to AIDS phobia can be traumatic and may harm the health of those with already lowered immune systems. See Welliseh, U.C.L.A. Psychological Study of AIDS, 19 Frontiers of Radiation Therapy & Oncology 155 (1985).

94 Moreover, if this Court were to permit, perhaps even encourage, employers to discharge those persons infected with the AIDS virus but whose bodies have fought progress of the disease, it would be weakening the very individuals whose systems may best fight the disease, and who offer our best hope for developing biological resistance to the disease.

might exclude persons infected with the AIDS virus from the protections of the Act.

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APPENDIX

APPENDIX

INTERESTS OF INDIVIDUAL AMICI CURIAE

This brief amici curiae is submitted on behalf of Doctors for AIDS Research and Education (DARE). DARE is composed of physicians and public health specialists dedicated to providing treatment to persons afflicted with Acquired Immune Deficiency Syndrome (AIDS), researching medical aspects of the disease, and educating the public about the AIDS virus and the individuals infected by it. As a whole, the members of DARE represent the fullest extent of medical knowledge and expertise currently able to be brought to bear on issues relating to AIDS. The following is a list of the members of DARE and their qualifications:

Neil Schram, M.D. is the present Chair of the Los Angeles City and County

AIDS Taskforce, the Kaiser Permanente AIDS Committee, and the ACLU Foundation of Southern California Ad Hoc Taskforce on AIDS and Civil Liberties. He is Assistant Clinical Professor of Medicine, UCLA School of Medicine and a staff doctor at Kaiser Permanente Medical Group of Southern California. He has treated large numbers of patients suffering from AIDS or AIDS-Related Complex (ARC).

Mervyn Silverman, M.D., M.P.H., is the current President of the American Foundation for AIDS Research. He is also Director of the Robert Wood Johnson Foundation AIDS Health Services Program. From 1977 to 1985 he served as the San Francisco Director of Health.

Gerald Friedland, M.D. is Associate Professor of Medicine and Associate Professor of Epidemiology and Social

Medicine at the Albert Einstein College of Medicine. He is also a physician at the Montefiore Medical Center, specializing in the treatment of persons with AIDS. He has treated more than 300 AIDS patients.

Donald Abrams, M.D. is Assistant Director of the Acquired Immunodeficiency Syndrome/Kaposi's Sarcoma Clinic at San Francisco General Hospital. He has treated more than 1,000 patients with acquired immune deficiency syndrome. He serves on the AIDS Advisory Committee of the San Francisco Department of Public Health and on the Scientific Advisory Committee of the AIDS Foundation of San Francisco. He presently is conducting clinical studies on Kaposi's Sarcoma, lymphadenopathy and opheresis in acquired immune deficiency syndrome-related conditions. He has

published over 35 articles on AIDS, as well as numerous book chapters on the subject.

Daniel William, M.D. is an instructor in clinical medicine at Columbia University in New York. He is Director of the AIDS Ambulatory Clinic at St. Luke's-Roosevelt Hospital Center. He is also a member of the American Medical Association AIDS Panel, the New York State AIDS Institute, and the Medical Advisory Board to the Gay Men's Health Crisis. He has published numerous articles on AIDS.

Harold Hawley, M.D. is Medical Director of the Whitman-Walker Clinic. He is a member of the District of Columbia Taskforce on AIDS and is Associate Pathologist for Microbiology at the Washington, D.C. Veteran's Administration Medical Center.

Alexandra Levine, M.D. is Executive Associate Dean and Professor of Medicine at USC School of Medicine. She is involved in AIDS research in the areas of treatment, natural history, specific drugs, and treatment and evaluation. She has treated over 500 people infected with the AIDS virus.

David Ostrow, M.D., Ph.D. is Director of the Psychobiology Program, University of Michigan School of Medicine. He is a member of the Steering Committee of the National Multi-Center AIDS Cohort Study and a member of the AIDS Expert Advisory Panel for the American Medical Association. He is organizer and Chairperson for the Chicago Area AIDS Taskforce and Chairperson for the Chicago Department of Health, AIDS Advisory Panel. He also organized the International AIDS Prospective

Epidemiology Network. He has worked with over 200 patients with AIDS.

Dennis McShane, M.D. is Acting Chief of Rheumatology at Palo Alto Veteran's Administration Hospital and Clinical Assistant Professor of Medicine at Stanford University. He founded the American Association of Physicians for Human Rights, and served as its President in 1982/83. From 1983 to 1986, he served on the Stanford Medical Center's AIDS Taskforce. In addition, Dr. Shane presently serves on the California AIDS Budget Taskforce and the California AIDS Strategic Planning Commission. He also presently chairs the Stanford Medical Center AIDS Committee. He has treated up to 100 people with AIDS and many more with ARC.

Peter Heseltine, M.D. is the Chief Physician and Hospital Epidemiologist of

the Los Angeles County/USC Department of Epidemiology, and Assistant Director of the Los Angeles County/USC Medical Center AIDS Clinic, which sees about one third of all patients with AIDS in Los Angeles County. He served as Coordinator of the USC AIDS Study Group in 1983/84. He presently is supervising a research study on health worker AIDS transmissions. He has treated more than 600 patients with AIDS.

Joel Weisman, D.O. co-directs the largest non-public AIDS unit in the country, located in Sherman Oaks, California. He is one of the doctors who first identified the clinical syndrome of AIDS and reported the syndrome to the Centers for Disease Control. He serves on the faculty of the UCLA Department of Medicine. He has treated more than 500 patients with AIDS and more than 1,500 patients with ARC.

James Lipsett, M.D. is Associate Director of the City of Hope National Medical Center, Division of Radiation Oncology, and an instructor at the USC School of Medicine. He serves on the Medical Advisory Committee for AIDS Project Los Angeles.

Stuart Nichols, M.D. is Associate Chief of Medical and Psychiatric Services at the Methadone Maintenance Treatment Program, Beth Israel Medical Center, New York City, and Senior Instructor in Psychiatry, Mount Sinai School of Medicine, City University of New York. He has edited a book entitled, Psychiatric Implications of AIDS, and written a chapter on psychotherapy and AIDS in another book. He has given numerous lectures on AIDS at conferences all over the United States. He serves as an AIDS consultant to the National

Institutes of Mental Health, Drug Addiction, and Allergy and Infectious Diseases. He also serves on the AIDS Committee of the American Psychiatric Association and the New York City District Branch Taskforce on AIDS. He has seen more than 500 patients with AIDS.

Roger Detels, M.D. is Professor of Epidemiology at UCLA School of Public Health, and served as Dean of that school from 1980 to 1985. He serves on the American Foundation of AIDS Research's Scientific Advisory Committee, and on the Southern California CARES Professional Advisory Taskforce for AIDS Project Los Angeles. He also serves as Chair of the Analysis Committee for the Multi-Center AIDS Cooperative Study. He has published articles on AIDS and has completed a study on the natural history of AIDS in gay men.

Constance Wofsy, M.D. is Co-Director of AIDS Activities at San Francisco General Hospital, and is Assistant Chief of the Infectious Diseases Division there. The AIDS clinic she oversees treats over 1,000 patients with AIDS or ARC each month. Dr. Wossy is the principal investigator for Women's AIDS Research and Education. She has researched the development of AIDS opportunistic infections and heterosexual modes of transmission. She also has lectured and published extensively on the subject of AIDS.

Nick Ifft, M.D. is one of the founding members of the Philadelphia AIDS Taskforce, and has served as its president since 1983. He has treated over 90 patients with AIDS and over 200 patients with ARC in the first six months of 1986.

Michael Roth, M.D. is Assistant Clinical Professor at U.C.L.A. Department of Medicine, Clinical Immunology and Allergy Section. He is co-chair of the California AIDS Commission and a member of the California Assembly Budget Task Force on AIDS. He serves on the staff of the U.C.L.A. AIDS Center, and as medical advisor to AIDS Project Los Angeles and the Los Angeles City Council. He has published numerous articles on AIDS and has treated over 200 persons with the disease.

Michael Kaiser, M.D. is the Director of Emergency Care at Children's Hospital in New Orleans, Louisiana, and Clinical Assistant Professor, Department of Pediatrics at both Louisiana State University School of Medicine and Tulane University Medical Center. He has lectured extensively on AIDS and HIV

testing. He is the leading pediatric expert on AIDS in Louisiana.

Allen McCutchan, M.D. is a Clinician and Associate Professor in the Division of Infectious Diseases, San Diego Medical Center, University of California. He serves on the University of California Taskforce on AIDS and has treated more than 150 people with AIDS.

Nicholaos Bellos, M.D. is Chief Medical Resident of Tulane University Affiliated Hospitals in New Orleans. He is a member of the Louisiana State Taskforce on AIDS and Chair of the Case Funding/ Public Awareness Subcommittee. He has treated more than 50 patients with AIDS.

Peter Wolfe, M.D. is former Associate Director of the UCLA AIDS Center. He is presently Assistant Clinical Professor of Medicine at UCLA School of

Medicine. In his private practice, he has treated several hundred patients with AIDS. He has published numerous articles on AIDS.

Hal Freeman, M.A. is a licensed psychotherapist. From January 1984 to February 1986, he served as Regional Director in the Office for Civil Rights, United States Department of Health and Human Services, Region IX, San Francisco, and served as Deputy Director for that office from 1968 to 1984. He now works with patients with AIDS and ARC and with AIDS-fearful persons.

Thomas Mundy, M.D. is Adjunct Assistant Professor of Pediatrics at UCLA School of Medicine and an attending staff physician at Children's Hospital, Los Angeles. He currently is researching the natural history of infection by the AIDS virus in

recipients of blood products. He has published papers on AIDS and has a number of manuscripts on AIDS in preparation. He has treated numerous children afflicted with AIDS.

William Christopher Mathews, M.D. is a Robert Wood Johnson Clinical Scholar at UCLA Medical Center and the Veteran's Administration Hospital, Westwood, California, where he practices acquired immune deficiency syndrome health services. He has treated over 60 patients with AIDS and over 300 patients with ARC. He also served on the San Diego Mayor's Taskforce on AIDS from 1985 to 1986, and presently serves on the AIDS Health Services Program of the Robert Wood Johnson Foundation.

Norbert Gilmore, M.D. is Associate Professor at the McGill University

Department of Medicine, and Associate Physician at the Royal Victoria Hospital in Montreal, Quebec. He chairs the Canadian National Advisory Committee on AIDS, and is a member of the Quebec AIDS Committee and the Canadian Health Association's Public Education Committee on AIDS. He has researched the epidemiology of AIDS and treated more than 60 persons with AIDS.

Marshall Forstein, M.D. is the Medical Director of the Gay and Lesbian Counseling Service, and the AIDS Action Committee in Massachusetts. He has treated over 100 patients with AIDS and many with ARC.

David McEwan, M.D. is the Chief of Family Medicine at Honolulu Medical Group. He served as President of the AIDS Foundation of Hawaii from 1983 to May 1986. He presently serves on the

Honolulu Mayor's Advisory Committee on AIDS and on the University of Hawaii's Ad Hoc AIDS Committee. He has treated more than 35 patients with AIDS and 150 patients with ARC.

A. Brad Truax, M.D. is a general medical practitioner in San Diego, California, whose practice is 75% AIDS-related. He has treated more than 75 patients with AIDS. He also has lectured and published articles on AIDS. He currently serves as Chair of the San Diego County Regional AIDS Taskforce, and is a member of the San Diego Mayor's Taskforce on AIDS.

Amy Ross, Ph.D. is a pathologist. She is an Adjunct Instructor, Department of Anatomy, USC School of Medicine. She has researched and published extensively on issues involving AIDS.

Robert Bolan, M.D. is an Assistant Clinical Professor at the University of California Division of Family and Community Medicine, and Medical Director of the Gay Health Care Clinic of the Presbyterian Hospital in San Francisco. He serves as President of the San Francisco AIDS Foundation, and as a member of the San Francisco Department of Public Health AIDS Coordinating Committee, the AIDS Taskforce of the Director of the San Francisco Department of Public Health, the San Francisco Mayor's AIDS Advisory Taskforce, and the San Francisco AIDS Foundation Board of Directors. He has treated more than 100 persons with AIDS and more than 300 with ARC.

Brian Willoughby, M.D. is a Staff Doctor at St. Paul's Hospital, Vancouver, British Columbia, Canada, and

is a staff member of the AIDS Care Team in Vancouver. He serves on the Advisory Board of AIDS. He also does research and has published articles on AIDS. He has treated more than 20 patients with AIDS.

James Cherry, M.D. is Professor of Pediatrics and Chief of the Division of Infectious Diseases at the U.C.L.A. School of Medicine Center for the Health Sciences. Since 1983, he has been involved in a study on the risk of contracting AIDS admidst health workers.

Kent Sack, M.D. has worked as a clinician in an AIDS-Related Complex (ARC) clinic for five years for the San Francisco City Health Department. Over 7,500 people with ARC have been seen in the clinic.